DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/15/2011 FORM APPROVED OMB NO. 0938-0391

		X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUII	LDING	01	COMPL		
		155290	B. WIN	G		06/27/2	011	
NAME OF D	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF I	KOVIDER OR SOLI EIER			701 AR	MORY ROAD			
ST ELIZA	ABETH HEALTHCAF	RE CENTER		DELPH	II, IN46923			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION DATE	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)	ENCY)		
K0000								
	Δ Life Safety Co	ode Recertification	K(	0000	St. Elizabeth Healthcare Cer	nter		
	=	sure Survey was			("the Provider") submits this Plan			
		he Indiana State			of Correction ("POC") in			
					accordance with specific			
	Department of				regulatory requirements. The submission of this POC does			
	accordance with 42 CFR 483.70(a).				indicate an admission by St.			
					Elizabeth Healthcare Center	Elizabeth Healthcare Center that		
	Survey Date: 0	6/27/11			the findings and allegations			
					contained herein are accurat			
	Facility Number	r: 000187			and true representations of the quality of care and services	ile		
Provider Number:		er: 155290			provided to the residents of S	St.		
	AIM Number: 100267300				Elizabeth Healthcare Center	. This		
					Plan of Correction shall serve	e as		
	Surveyor: Bridg	get Brown, Life			the credible allegation of	ı		
Safety Code S		ecialist			compliance with all state and federal requirements govern			
					the management of this facili			
	At this Life Safe	ety Code survey, St.			is thus submitted as a matter	of		
		hcare Center was			statue only.			
	found not in co							
		or Participation in						
	Medicare/Medic							
	=	Subpart 483.70(a), Life Safety from Fire and the 2000 edition of						
	the National Fir							
		PA) 101, Life Safety						
	Code (LSC), Cha	de (LSC), Chapter 19, Existing						
	Health Care Occupancies and 410							
IAC 16.2.								
	This one story	facility was						
	determined to be of Type V (111) construction and was fully							
LABORATOR	Y DIRECTOR'S OR PROV	TDER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

15KT21

Facility ID:

If continuation sheet

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF CORRECTION	IDENTIFICATION NUMBER:  155290	(X2) M A. BUII B. WIN	LDING	01 	COMPL 06/27/2	ETED	
NAME OF PROVIDER OR SUPPLIER  ST ELIZABETH HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE  701 ARMORY ROAD  DELPHI, IN46923					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE	
	alarm system videtection in the spaces open to facility has the had a census of this survey.  Quality Review by Safety Code Special 06/30/11.  The facility was compliance with aforementione	e corridors and the corridors. The capacity for 78 and f 61 at the time of  Robert Booher, REHS, Life list-Medical Surveyor on  s found not in th the						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155290	(X2) MU A. BUIL B. WING	LDING	01	(X3) DATE S COMPL <b>06/27/2</b> (	ETED
NAME OF PROVIDER OR SUPPLIER ST ELIZABETH HEALTHCARE CENTER				701 ARN	DDRESS, CITY, STATE, ZIP CODE MORY ROAD , IN46923		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K0051 SS=C	according to NFPA Code, to provide e any part of the bui complete fire alarm alarm initiation, au extinguishing syste in patient sleeping provided that man 200 feet of nurse's located in the path written records of reliable second so Fire alarm system accordance with N maintenance are k is remote annuncia system to an appr 19.3.4, 9.6 Based on record interview, the f ensure docume testing of 1 of system's composuch as smoke sensors and fir stations was co 7–3.2 requires initiating device detectors, heat pull stations, a control equipm annually. NFPA requires the ins include location	ces or equipment is installed A 72, National Fire Alarm effective warning of fire in Iding. Activation of the in system is by manual fire atomatic detection or em operation. Pull stations areas may be omitted ual pull stations are within a stations. Pull stations are of egress. Electronic or tests are available. A urce of power is provided. IFPA 72 and records of test readily available. There ation of the fire alarm oved central station.  If review and accility failed to entation for the 1 fire alarm onents and devices detectors, heat e alarm pull emplete. NFPA 72, fire alarm system es such as smoke sensors, fire alarm and fire alarm ent be tested A 72, 7–5.2.2 spection shall	K0	0051	1. Corrective ActionThe vene who completes our fire syste has been notified and will ide each smoke detector, heat sensor and fire alarm pull state by location, serial number, the test/inspection done and whe each device passed or failed See attachment #12. Potent AffectedThe Plant Operations Director will assure that documentation from the vene completed according to the requirements of NFPA 72, 7-5.2.2.3. Systemic ChangeInspection document will include the required components of the regulation include location, serial number test/inspection done and whe each device passed or failed Corrective Action MonitorThe	mentify  ation eether dor is  ation to er, ether e.4.	07/26/2011

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

I5KT21

Facility ID:

000187

If continuation sheet

Page 3 of 6

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155290		(X2) MU A. BUIL		NSTRUCTION 01	(X3) DATE S	ETED	
		155290	B. WING			06/27/2	011
NAME OF PROVIDER OR SUPPLIER					DDRESS, CITY, STATE, ZIP CODE  MORY ROAD		
	ABETH HEALTHCA				, IN46923		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERNCED TO THE APPROPRIATE DEFICIENCY)		DATE
	and whether ea	ach initiating device	1		inspection reports will be		
	passed or faile	d. This deficient		monitored for compliance by Plant Operations Director an			
	practice could	affect all occupants.			Executive Director.5. Completion Date July 26, 2011		
	Findings includ	le:					
	Based on reviev	w of the facility's					
	quarterly Perio	dic Fire Alarm					
	Inspection and	Test Reports for					
	the past year w						
	maintenance d						
		on 06/27/11 at 3:10					
	•	s no itemized list of					
		ystem components ch as manual pull					
		ne locations and					
		isual and functional					
		itemized list for					
		rs was the Smoke					
	Detector Sensit	ivity Test dated					
	11/02/10. The	e administrator and					
	maintenance d	irector said at the					
		review there was no					
	other documen	tation.					
	3-1.19(b)						
K0144		spected weekly and bad for 30 minutes per					
SS=F	month in accordar 3.4.4.1.	· · · · · · · · · · · · · · · · · · ·					
	Based on obser	vation and	K0	144	Corrective ActionThe E to has been installed and tested	-	07/13/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155290		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE COMPL		
				LDING	01	06/27/2	
		100200	B. WIN		A DDDEGG CITY GTATE ZIR CODE	00/2//2	011
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE		
ST ELIZABETH HEALTHCARE CENTER			701 ARMORY ROAD DELPHI, IN46923				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG				PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
IAG		facility failed to		IAG	the facility's Emergency		DAIL
	ensure 1 of 1	· · · · · · · · · · · · · · · · · · ·			Generator by Huston Electric	<b>)</b> .	
		s equipped with a			See Attachment #2.2. Potent	- 1	
	~	I stop. LSC 7.9.2.3			AffectedThe emergancy stop allow staff to disegage the		
		gency generators			generator in an emergency.3	i.	
	1 .	er to emergency			Systemic ChangeThe staff w		
	1 ' - '	ns shall be installed,			inserviced by the Plant		
	tested and mai				Operations Director on the purpose of and protocol for u	se of	
	accordance wit				the emergecy stop. This		
					inservice is scheduled to beg	jin on	
	Standard for Emergency and Standby Power Systems. NFPA 110, 1999 edition, 3–5.5.6 requires Level II installations shall				July 13, 2011. 4. Corrective Action MonitorThe Plant		
					Operations Director is respon	nsible	
					for proper maintenance and		
	I	manual stop station			monitoring of the emergency stop. Documentation will be		
		ar to a break-glass			required for the use of the		
	1	elsewhere on the			emergency stop to include d	ate,	
		e the prime mover			time, reason, outcome and staff		
	l <sup>-</sup>	ide the building.			person initiating the stop.5. Correction Date 07/13/2011.		
	NFPA 37, Stand				001100110111101111111111111111111111111		
	· ·	d Use of Stationary					
	Combustion Er	•					
		B Edition, at 8-2.2(c)					
	requires engin						
	horsepower or						
	provision for the shutting down the engine at the engine and from a remote location. This deficient practice could affect all occupants.						
	Findings includ	de:					
		w of the generator					
	maintenance re	ecords on 06/27/11					

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155290		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY  A. BUILDING B. WING				
NAME OF PROVIDER OR SUPPLIER ST ELIZABETH HEALTHCARE CENTER			701 AR	ADDRESS, CITY, STATE, ZIP CODE MORY ROAD II, IN46923	E	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPF DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	director and act was no docume indicating the ligenerator. The director said at review, it was repoised with on the generation the generation confirmed there located emerge off device instates.	the time of record more than 100 The generator was an emergency stop or itself. He e was no remotely ency generator shut alled but installation is planned. It was				